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To: Capital Investment Fund Interested Parties
From: GOHPF
CC: Advisory Council on Health Systems Development
Subject: Proposed Capital Investment Fund Rule
Date: Friday, November 21, 2008

As posted in the Secretary of State's weekly notices,[1] there will be a public hearing on the proposed Capital Investment Fund Rule (attached and posted at www.maine.gov/gohpf) at 2:00 pm, December 11th, 2008 at Conference Room C, 35 Anthony Avenue, Augusta, Maine. The deadline for comments is close of business Monday, December 22, 2008, sent to Peter Kraut, Health Policy Analyst, Governor's Office of Health Policy & Finance, 15 State House Station, Augusta, ME 04333 or Peter.Kraut@maine.gov.

Background / Reason for Proposed Amendment

The CIF is one of the only cost containment tools available in state law. It places a cost limit on how much may be added to the health care system each year by capital investments approved under the Certificate of Need program. The CIF establishes a measure of affordability against which CON decisions about need can be made; it balances need and affordability, recognizing that supply of health care services increases utilization and that increased utilization does not necessarily improve health outcomes.

The CIF is set annually using a formula and public process laid out in regulation. In reviewing the CIF and receiving public comments each year that the CIF has been in place, GOHPF and the ACHSD heard testimony from hospitals that the process in the current regulation:

(1) makes it difficult for hospitals to do strategic planning, because the available CIF amount can vary significantly from one year to the next, and

(2) results in a number that is too low (based in part on its adjusting for affordability using a cost measure that is based on the Medicare wage index, which the MHA says makes Maine hospitals appear less efficient than other hospitals).

[1] www.maine.gov/sos/cec/rules/notices/2008/111908.htm

Consumer groups and a payer/employer on the other hand, have testified in support of the rule in its current form.

In March 2008, the Legislature's Health and Human Services Committee – in voting to reject a bill (LD 2152) during the 2008 legislative session that would have eliminated the CIF – sent a letter to GOHPF asking that GOHPF and the ACHSD "conduct a through review of the capital investment fund…as it relates to the existing formula and in the context of some of the concerns that have been raised during your regulatory hearings and as part of the legislative hearing on LD 2152."

The 2008-09 State Health Plan accordingly stated that "the ACHSD will – prior to the setting of the 2009 CIF amount – examine the possibility of revising the regulation to deal with these issues, including the possibility of a multi-year CIF."

Process to Arrive at Proposal

The ACHSD convened a subcommittee with ACHSD members representing hospitals, consumers, and employers to address this issue. The workgroup decided at its June 9 2008 meeting to proceed in its process of deciding how and whether to revise the CIF rule by instructing that staff should:

- meet individually with as many stakeholders as possible to get their ideas;
- summarize all the ideas in a single document – without identifying who suggested what – to ensure that we have characterized the ideas accurately and have not omitted anything; and
- share the edited document with the workgroup, which will recommend whether and which ideas to proceed with in proposing changes to the full ACHSD.

GOHPF sent invitations to 39 stakeholders and proceeded to meet over the summer with seventeen who responded and receive written comments from an additional two. Of the nineteen respondents: five represented hospitals; two represented non-hospital providers; two represented consumers; two represented insurers; six represented employers; and two were "other."

The workgroup reviewed the document summarizing the stakeholder input at its August 12 meeting and instructed GOHPF to draft a concept proposal based on deliberations at the meeting.

The full ACHSD then reviewed that concept proposal at its September 26 meeting. The council instructed GOHPF to draft language for the council to review at its October meeting, with the approved language to be the language of the proposed rule for rulemaking. The ACHSD approved the language at its October 24 meeting.

Summary of the Proposal; Rationale for Various Components

1. The CIF process. The CIF will operate on a three year time-frame to accommodate concerns that the current CIF rule impedes hospital planning.

(1) After a one year transition period in 2009, set the CIF for three years at a time, and announce the value well in advance of the coming three year period. While the CIF will cover a three-year period, CONU will continue its current practice of ruling on projects one year at a time.

(2) Regardless of the size of a project and the year in which the project is reviewed, costs will be fully debited against the CIF in the year in which the project is approved. The total debits of projects approved during the three year effective period may not exceed the CIF for that three year period.

A detailed explanation of the rationale behind this component of the proposal – along with other alternatives considered – can be found on pages 3-5 of the Draft Capital Investment Fund (CIF) Proposal reviewed by the ACHSD at its September 26th meeting (see www.maine.gov/tools/whatsnew/attach.php?id=61658&an=2).

2. The CIF Calculation. Set the hospital portion of the CIF at an amount that is based on amounts that have resulted from the current rule, but without the adjustments cited by hospitals as problematic.

This would result in a CIF set at 0.31% of statewide hospital operating expenses, which is higher than the 0.25% that resulted from the first four CIF calculations, but lower than the 0.41% in the five years prior to enactment of the CIF (see pages 5-7 of the Draft CIF Proposal reviewed by the ACHSD at its September 26th meeting (www.maine.gov/tools/whatsnew/attach.php?id=61658&an=2) for an explanation of where 0.31% comes from, as well as other alternatives considered to sizing the fund).

This results in the following estimated CIFs (based on the most recently available data; future CIFs could differ based on the extent to which statewide hospital operating expenses differ from projected).

Table 1. Projected Hospital Portion of CIFs Under GOHPF Proposal ($ mil)

	2009	2010	2011	2012	2013	2014	2015
0.31% of op xpns	12.4	13.6	15	16.5	18.2	20	22
CIF	**12.4**	**45.1**			**60.1**		

The rule continues to set aside an amount for small projects but increase the set-aside from 10% to 15% and defines small projects as those with a CIF debit less than $1.2 million *and* capital costs less than $15 million. Using this definition, roughly half of all projects approved from 1999-2008 were small and roughly half were large, and 13% of all costs approved from 1999-2008 were from small projects. The amounts in the definition will be annually adjusted for inflation.

3. <u>Debiting the Costs of Projects Approved Under Earlier CIFs.</u>

The available 2008 CIF is $4.37 mil. Once that is fully used by the projects approved under the 2008 review cycle (EMMC and St. Mary's have been approved; CMMC is still outstanding), there will still be from $14.05 mil to $17.12 (depending on the CMMC outcome) to debit beyond 2008.

The proposed rule would reduce the outstanding debit by a total of $7,048,205, which – as shown in the table below – is the difference between the total of the first four CIFs and what the first four CIFs would have been had those CIF's been set at 0.31% of operating expenses. (The rationale behind the Council's decision on this point is that it is consistent with the purpose of the CIF in general as well as the new rule: it recognizes that the rule deems 0.31% as an acceptable CIF level and treats debits from past projects accordingly.)

	CIF 1	CIF 2	CIF 3	CIF 4	tot
Actual hosp CIF calc.	$5,759,400	$8,083,188	$8,735,671	$9,699,223	$32,277,482
0.31% of op xpns	$8,477,723	$9,325,600	$10,251,980	$11,270,384	$39,325,687
Difference	$2,718,323	$1,242,412	$1,516,309	$1,571,161	**$7,048,205**

That will leave an outstanding debit from 2008 approvals of $7.0 to $10.1 mil (depending on the CMMC outcome) to debit beyond 2008.

Some of that amount could be debited against 2009 CIF, depending on how much is unused (as shown previously, the 2009 hospital CIF is projected to be $12.4 mil). $1.42 mil of the 2009 CIF will be will be used by the third of three debits from Maine Med's 2007 Emergency Department Expansion, leaving $11 mil available for 2009 projects, with any remaining amount then being used by 2008 debits.

Any 2008 debits remaining after debiting against the 2009 CIF will be debited proportionally against the 2010-2012 CIF and 2013-2015 CIF (i.e., 45% will be debited against the 2010-2012 CIF, and 55% will be debited against the 2013-2015 CIF), slightly reducing the amounts available for new projects from the projected amounts in Table 1.

4. <u>Non-hospital portion of the CIF.</u> As has been the practice under the first four CIFs:

(a) there will also be a non-hospital CIF component above and beyond the hospital CIF component;

(b) its value will be calculated by multiplying the hospital portion of the CIF by (0.125) / (0.875);

(c) in no event may balances: (1) in the Non-Hospital component be used by hospital projects, or (2) in the Hospital component be used by non-hospital projects.

Conclusion

The CIF -- which creates a budget for the CON program to assure affordability -- is one of the only cost containment tools available in state law, so it is important that the CIF is preserved.

Following extensive public input, the proposed rule addresses concerns raised about the original rule, while also strengthening the CIF as cost containment and planning tool:

- It sets the CIF according to a straightforward formula -- 0.31% of statewide operating expenses -- which addresses concerns that had been raised about the current formula.
- It facilitates effective health system planning by setting the CIF once every three years for a three year period. This provides more predictability than in the current CIF, so that the CIF process does not impede hospital strategic planning.
- The three year CIF also enhances DHHS's ability to ensure economic and orderly development of the state's health care system by giving DHHS a better sense of all projects that providers wish to undertake so that DHHS can work with applicants so that projects can be adapted and approved to meet needs within the affordability limit.